Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN1934 | A. BUILDING: 01 - MAIN BUILDING<br>B. WING _____ | 06/05/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MCKENDREE VILLAGE INC | 4347 LEBANON ROAD<br>HERMITAGE, TN 37076 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>During the Fire Safety portion of the annual licensure survey conducted on 06/05/2018, no deficienices were cited under the Tennessee Department of Health, Board for Licensing health Care Facilities, Chapter 1200-08-06, Standard for Nursing Homes. | N 000 | | |

Division of Health Care Facilities

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Suzanne Hogan LNHA | Administrator | 6-26-2018 |